Electronic Billing Certification Form
Emergency Medical Services Appropriation (EMSA)
Contract Back Program

Group MediCal No. _____

Group Name: _____

Physician's Name: _____ Provider No.: _____

Affidavit of Physician or Physician's Representative

This is to certify that the information contained on these Emergency Medical Service Appropriation (EMSA) Claims and data disks to be true, accurate, and complete. The physician/physician's group has read, understands and agrees to be bound by and comply with the policies, conditions and statements contained in the EMSA Policies and Procedures Manual, related statutes and regulations and the Annual Physician Enrollment and Claim Certification. I further agree to cease all current and any future collection efforts when I receive any level of reimbursement of these claims from the EMSA Contract Back Program.

By submitting and signing this certification form, I, as the attending physician or authorized certified representative, also hereby certify that on the third billing attempt, a copy of the "Notice of Privacy Practices" for the EMSA Contract Back Programs was sent and/or provided to all patients named on this electronic billing disk being submitted as required by the EMSA Contract Back Programs.

Total Claims Submitted: _____

Total Amount Claimed: $_____

☐ A Copy of the "Notice of Privacy Practices" was sent to all patients listed on this data disk being submitted.

_____ _____

Date Authorized Representative's Signature